

Provider NPI:

Group NPI:

EIN:

Verification of Benefits Form

Obtain copy of front & back of insurance card card & copy of patient's driver license

Patient's Name: _____

Patient's Date of birth: _____

Home Address : Street _____ City _____ State _____ Zip _____

Name of Insurance: _____ Insurance ID Number: _____

Applicable ICD 10 codes:

Date: _____ Time: _____ Representative: _____

Policy type: PPO HMO POS Other _____

Benefit period: From _____ To _____

Is this a FULLY funded plan? Yes No Is this a SELF-funded plan? Yes No

Is this policy a grandfathered plan not needing to adhere the ACA? Yes No

Does this policy have Nutrition Counseling/Medical Nutrition Therapy Benefits? Yes No

Which CPT codes are covered on this policy? 97802 97803 97804 S9470 99401-99404

Are BOTH preventative nutrition services covered under Health Care Reform AND medical benefits covered? Yes No

Does this plan cover telehealth services? Yes No

Is there a co-pay for telehealth services Yes No Amount \$ _____

Does this plan require an MD referral Yes No

Does this plan require prior authorization for nutrition services Yes No Comments

Does this plan require the dietitian submit medical documentation Yes No

Fax # to send notes _____

Coverage for PREVENTATIVE MNT services includes: Comments:

Number of visits _____
Limit on number of units _____
Deductible applies \$ _____
Co-pay applies \$ _____
Co-insurance applies _____ %

Coverage for MEDICAL MNT services includes: Comments:

ICD 10 codes to verify _____
Number of visits _____
Limit on number of units _____
Deductible applies \$ _____
Co-pay applies \$ _____
Co-insurance applies _____ %

Reference # for this call _____